CMBD-125630654 SERFF Tracking Number: State: Arkansas Filing Company: Combined Insurance Company of America State Tracking Number: 38876

Company Tracking Number: 164016-AR - APPLICATION FOR ACCIDENT AND HEALTH INSURANCE

TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only

Product Name: 164016-AR - Application for Accident and Health Insurance

164016-AR - Application for Accident and Health Insurance/164016-AR - Application for Accident and Health Insurance Project Name/Number:

## Filing at a Glance

Company: Combined Insurance Company of America

Product Name: 164016-AR - Application for SERFF Tr Num: CMBD-125630654 State: ArkansasLH

Accident and Health Insurance

TOI: H02I Individual Health - Accident Only SERFF Status: Closed State Tr Num: 38876

Sub-TOI: H02I.000 Health - Accident Only Co Tr Num: 164016-AR -State Status: Approved-Closed

> APPLICATION FOR ACCIDENT AND HEALTH INSURANCE

Filing Type: Form Co Status: Reviewer(s): Rosalind Minor

> Disposition Date: 06/04/2008 Author: Deborah Shortridge Date Submitted: 05/06/2008 Disposition Status: Approved-

> > Closed

Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

#### General Information

Project Name: 164016-AR - Application for Accident and Health Status of Filing in Domicile: Not Filed

Project Number: 164016-AR - Application for Accident and Health Date Approved in Domicile:

Insurance

Requested Filing Mode: Review & Approval **Domicile Status Comments:** Explanation for Combination/Other: Market Type: Individual Submission Type: New Submission Group Market Size:

Overall Rate Impact: Group Market Type: Filing Status Changed: 06/04/2008 State Status Changed: 06/04/2008 Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Please see attached cover letter

Company Tracking Number: 164016-AR - APPLICATION FOR ACCIDENT AND HEALTH INSURANCE

TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only

Product Name: 164016-AR - Application for Accident and Health Insurance

Project Name/Number: 164016-AR - Application for Accident and Health Insurance/164016-AR - Application for Accident and Health Insurance

## **Company and Contact**

#### **Filing Contact Information**

Deborah Shortridge, Senior Policy Analyst Deborah\_Shortridge@aon.com

 1000 Milwaukee Avenue
 (847) 953-1534 [Phone]

 Glenview, IL 60025
 (847) 953-1557[FAX]

**Filing Company Information** 

Combined Insurance Company of America CoCode: 62146 State of Domicile: Illinois

1000 Milwaukee Avenue Group Code: 317 Company Type:
Glenview, IL 60025 Group Name: State ID Number:

(847) 953-1531 ext. [Phone] FEIN Number: 36-2136262

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## **Filing Fees**

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? Yes
Fee Explanation: IL - \$50
Per Company: No

COMPANY AMOUNT DATE PROCESSED TRANSACTION #

Combined Insurance Company of America \$50.00 05/06/2008 20113905

Company Tracking Number: 164016-AR - APPLICATION FOR ACCIDENT AND HEALTH INSURANCE

TOI: H021 Individual Health - Accident Only Sub-TOI: H021.000 Health - Accident Only

Product Name: 164016-AR - Application for Accident and Health Insurance

Project Name/Number: 164016-AR - Application for Accident and Health Insurance/164016-AR - Application for Accident and Health Insurance

# **Correspondence Summary**

## **Dispositions**

Status	Created By	Created On	Date Submitted
Approved- Closed	Rosalind Minor	06/04/2008	06/04/2008
Approved- Closed	Rosalind Minor	05/07/2008	05/07/2008

#### **Amendments**

Item	Schedule	Created By	Created On	Date Submitted
Application for Accident and Health	Form	Deborah Shortridge	06/04/2008	06/04/2008
Insurance 6-04-08 Filin Letter	g Supporting Document	Deborah Shortridge	06/04/2008	06/04/2008

 ${\it Company Tracking Number:} \qquad {\it 164016-AR-APPLICATION FOR ACCIDENT AND HEALTH INSURANCE}$ 

TOI: H021 Individual Health - Accident Only Sub-TOI: H021.000 Health - Accident Only

Product Name: 164016-AR - Application for Accident and Health Insurance

Project Name/Number: 164016-AR - Application for Accident and Health Insurance/164016-AR - Application for Accident and Health Insurance

## **Disposition**

Disposition Date: 06/04/2008

Implementation Date: Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

 ${\it Company Tracking Number:} \qquad 164016{\text{-}AR-APPLICATION FOR ACCIDENT AND HEALTH INSURANCE}$ 

TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only

Product Name: 164016-AR - Application for Accident and Health Insurance

Project Name/Number: 164016-AR - Application for Accident and Health Insurance/164016-AR - Application for Accident and Health Insurance

Item Type	Item Name	Item Status	<b>Public Access</b>
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Readability Certification	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	Variable Memorandum	Approved-Closed	Yes
Supporting Document	6-04-08 Filing Letter	Approved-Closed	Yes
Form (revised)	Application for Accident and Health	Approved-Closed	Yes
Form	Insurance Application for Accident and Health Insurance	Withdrawn	No

 ${\it Company Tracking Number:} \qquad {\it 164016-AR-APPLICATION FOR ACCIDENT AND HEALTH INSURANCE}$ 

TOI: H021 Individual Health - Accident Only Sub-TOI: H021.000 Health - Accident Only

Product Name: 164016-AR - Application for Accident and Health Insurance

Project Name/Number: 164016-AR - Application for Accident and Health Insurance/164016-AR - Application for Accident and Health Insurance

## **Disposition**

Disposition Date: 05/07/2008

Implementation Date: Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

 ${\it Company Tracking Number:} \qquad 164016{\text{-}AR-APPLICATION FOR ACCIDENT AND HEALTH INSURANCE}$ 

TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only

Product Name: 164016-AR - Application for Accident and Health Insurance

Project Name/Number: 164016-AR - Application for Accident and Health Insurance/164016-AR - Application for Accident and Health Insurance

Item Type	Item Name	Item Status	<b>Public Access</b>
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Readability Certification	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	Variable Memorandum	Approved-Closed	Yes
Supporting Document	6-04-08 Filing Letter	Approved-Closed	Yes
Form (revised)	Application for Accident and Health	Approved-Closed	Yes
Form	Insurance Application for Accident and Health Insurance	Withdrawn	No

Company Tracking Number: 164016-AR - APPLICATION FOR ACCIDENT AND HEALTH INSURANCE

TOI: H021 Individual Health - Accident Only Sub-TOI: H021.000 Health - Accident Only

Product Name: 164016-AR - Application for Accident and Health Insurance

Project Name/Number: 164016-AR - Application for Accident and Health Insurance/164016-AR - Application for Accident and Health Insurance

**Amendment Letter** 

Amendment Date:

Submitted Date: 06/04/2008

Comments:

Please see attached cover letter dated 6-04-08.

**Changed Items:** 

Form Schedule Item Changes:

Form Schedule Item Changes:

Form	Form	Form	Action	Form	Previous	Replaced	Readability	Attachments
Number	Туре	Name		Action	Filing #	Form #	Score	
				Other				
164016-AR	Application/	EApplication	Initial				50	164016-
	nrollment	for Accident						AR.pdf
	Form	and Health						
		Insurance						

#### **Supporting Document Schedule Item Changes:**

User Added -Name: 6-04-08 Filing Letter

Comment:

6-04-08 - Filing Letter 164016-AR.pdf

 SERFF Tracking Number:
 CMBD-125630654
 State:
 Arkansas

 Filing Company:
 Combined Insurance Company of America
 State Tracking Number:
 38876

 ${\it Company Tracking Number:} \qquad 164016{\text{-}AR-APPLICATION FOR ACCIDENT AND HEALTH INSURANCE}$ 

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Product Name: 164016-AR - Application for Accident and Health Insurance

Project Name/Number: 164016-AR - Application for Accident and Health Insurance/164016-AR - Application for Accident and Health Insurance

## Form Schedule

Lead Form Number: 164016-AR - Application for Accident and Health Insurance

Review	Form	Form Type	Form Name	Action	Action Specific	Readability	Attachment
Status	Number				Data		
Approved-	164016-AF	R Application	/Application for	Initial		50	164016-
Closed		Enrollment	Accident and Health				AR.pdf
		Form	Insurance				

APPLICATION NUMBER

5 0 0 1

5001164016

Section 1 – BASIC INFORMATION (Required for	r all products.)	LANGUAGE PREFERENCE E S F	
M F INSURED'S FIRST NAME		LAST NAME	
INSURED'S RESIDENCE ADDRESS		RESIDENCE PHONE NUMBER	
CITY		STATE ZIP	
INSURED'S DATE OF BIRTH INSURED'S AGE CAL	L TYPE ADDRESS	REF/LINK	
MM DD YYYYY	e Business	POLICY NUMBER	_
INSURED'S BILLING ADDRESS IF DIFFERENT FROM RESIDENCE		SOCIAL SECURITY NUMBER	
CITY		STATE ZIP	
Is any person applying for coverage on Medicaid? XYES XN	IO Will this pol	licy replace any existing policies? YES NO	
An Authorized Interviewer <u>may</u> call to obtain additional information rec	•	, , , , , , , , , , , , , , , , , , , ,	ıll•
Home Business ( )	7		,111.
,			
	· · · · · · · · · · · · · · · · · · ·	3:00 pm - 6:00 pm After 6:00 pm	
(Required for Income Protector and optional for other coverages INSURED'S BUSINESS NAME	-)	BUSINESS PHONE NUMBER	
INSURED'S BUSINESS ADDRESS			
CITY		STATE ZIP	
(Required if Payor different from Insured.)			
PAYOR'S FIRST NAME (IF OTHER THAN INSURED) MIDDLE INITIAL	LAST NAME		
PAYOR'S RESIDENCE ADDRESS (IF OTHER THAN INSURED)			
CITY		STATE ZIP	
(Required for Critical Care Protector.)			
BENEFICIARY'S FULL NAME (IF REQUIRED)		RELATIONSHIP TO INSURED	
Section 2 – EMPLOYMENT & INCOME INFORMATION	(Required if applying	ing for Income Protector only.)	
Insured's Occupation			
Please describe all employment duties performed in detail:			
_ round account an arrange of the country account			
3. I certify that my gross annual earnings, or net earnings if self-em	ployed, at time of app	plication (without overtime, unless	
overtime is contractual, and without other bonuses or incentives)	is: \$	7 V. N.	
4. Are you self employed or have you been working for the same er	mployer for less than	6 months? (A telephone interview Yes No	
may be required.)		X X	
5. Do you currently work in your primary occupation, performing all	primary duties, and v	work at least 30 hours or more per week?	
6. Do you currently have any other in force disability coverage with		XX	



## Section 3 – UNDERWRITING INFORMATION (Required for Income Protector and Critical Care Protector only.)

or	taken ar	sured rece ny prescrip	ived	BS.						Insu	rod
or	taken ar			any medical ADV						IIISU	ıcu
		iy prescrip	tion.	•			m a member	of the medical profes	ssion,	Yes	<u>No</u>
	Angina,						.9		10	Y	Y
								art valve replacemer	π?		
		-		er, cirrhosis of the	_	·					
				ain tumor, Hodgki							
d. Alzheimer's disease, dementia, Parkinson's disease, Multiple Sclerosis?											
e.	Chronic	Obstructi	ve Lı	ung/Pulmonary di	sease, Empl	nysema or c	ther lung dise	ase requiring oxyge	า?		
f.	Manic d	lepression	, sch	nizophrenia, alcoh	olism or drug	g addiction?					
2. Is	the insur	red listed of	on th	is application for i	nsurance an	insulin dep	endent diabet	ic?			
				•				naving AIDS (Acquire / (Human Immunode			
4. Ha	as the ins	sured beer	n cor	nvicted of reckless	driving or d	Iriving unde	r the influence	of alcohol within the	e past 5 years?		
5. Is	the insur	red curren	tly o	n Disability? (excl	uding Military	y Disability)					
lf a	any of th	ne above	ques	stions are answe	red "Yes", t	he insured	is not eligibl	e for coverage.			
				or or received Dis in the last 12 mon	•	its (includin	g that from Wo	orker's Compensatio	n, Social Security		
				• •			•	betic taking oral med alifies applicant.)	lication and/or		
				as a member of the back, neck, spine	•	ofession dia	agnosed you v	vith or treated you fo	r an injury,		
				sured's parents, br they were under th			liagnosed with	heart disease, cand	er, or any		
10. Wi	ithin the p	past 5 yea	ırs ha	ave you had any r	nedical advi	ce, diagnost	tic tests or trea	atment from a memb	er of the		
flu	, colds a	nd routine	phys		s answered	•		ondition(s) not listed  10 explain below.)			
•	•					nd/or evalu	ation of vou	r application an exc	lusionary rider for	specif	ic
				cational activitie					,	-	
Н	lealth Cor	ndition	l	Medication/Dosage	Treatment?	Surgery?	Dates	Physician(s) Name: Ad	dress (Street, City, State	e, Zip) &	Phone
					Yes No	Yes No					
					IGS INO	NO NO					
					Yes No	Yes No					
					Yes No	Yes No					



Section 4 – PLAN SELECTION  FORM NUMBER PLAN CODE Accident Protector If applying for Accident/Sickness, the following qualifying question must be answered:  Qualification Question – Read Carefully: To the best of your knowledge and belief, have you or any eligible dependent listed below had any advice or treatment for cancer, diabetes, stroke, heart attack, or other heart condition within the last five (5) years?  Insured: Yes No Spouse: Yes No Children: (Answer for each eligible child below)					
Cancer Care Protector  FORM NUMBER PLAN CODE C A P  Individual Plan Silver (Plan I) Family Plan Gold (Plan II)  Qualification Question – Read Carefully: To the best of your knowledge and belief, have you or any eligible dependent listed below had any advice or treatment for cancer, or skin cancer within the last ten (10) years?  Insured: Yes No Spouse: Yes No Children: (Answer for each eligible child below)					
Critical Care Protector  FORM NUMBER PLAN CODE AMOUNT OF INSURANCE  1 6 5 2 1 C C P \$ Paid Up Rider YES NO 2 0 Years  Has the insured used tobacco products in any form in the last 12 months? Insured: YES NO					
Income Protector  FORM NUMBER PLAN CODE Monthly Benefit  1 9 8 1 9 D I 1 \$ D 6 months 0 1 year 0 2 years  Elimination Period 14 30 90 days  Occupation Class					
Section 5 – PREMIUM & BILLING INFORMATION (Required for all products.)  RENEWAL MODE ANNL. S.A. MO. TPP Please charge or debit my checking account monthly.  Preferred Billing Date TOTAL MODAL PREMIUM \$					
Section 6 – DEPENDENT INFORMATION (Required if applying for Dependent Coverage Accident & Sickness, Cancer Care Protector).  SPOUSE'S FIRST NAME  Middle SPOUSE'S DATE OF BIRTH					
Child's Name (First Initial Last)  Birthdate: Mo/Day/Yr Qualification Question Y N  M M D D Y Y					



## Section 7 – DECLARATIONS – This section must be read, signed, and dated by Insured.

#### PLEASE READ CAREFULLY

It is very important that you review the application carefully. Misstatements or omissions whether made in writing or orally for any portion(s) of the application that are completed through use of telephone or other electronic means, could cause an otherwise valid claim to be denied. Please check the application carefully and advise your agent/producer if any information is not correct or not complete or if any medical history has not been included. I understand that any insurance applied for will not take effect unless and until Combined Insurance Company of America approves my application, the contract is issued, and the required premium is received by Combined Insurance Company of America.

In applying for this coverage, I represent and affirm the following:

- The information which I have given as recorded on this Application including income verification is true and complete to the best of my knowledge and belief.
- 2. I have received the Medical Information Bureau (MIB) Disclosure Statement, the notice under the Fair Credit Reporting Act, Notice of Information \_\_ Practices, and (if applicable) Outline of Coverage.
- 3. If applying for an Accident Only policy, I understand that the policy does not provide benefits for loss from sickness.
- 4. If applying for Critical Care Protector, I understand that the policy: 1) is NOT major medical and NOT meant to replace medical expense insurance; and 2) is NOT life insurance; and I am not covered by any Title XIX program (Medicaid or any similar name).
- 5. If applying for the Cancer Care Protector Policy, I understand that the policy is cancer only and does not pay benefits for loss from any other sickness or from accidents. FOR PERSONS ELIGIBLE FOR MEDICARE: I acknowledge receipt of the "Guide to Health Insurance" and duplication notice.

#### **AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

I authorize Combined Insurance Company of America or its reinsurers to acquire from and authorize any hospital, physician, medical practitioner, clinic, medically related facility, insurance company, the Medical Information Bureau, Inc. (MIB) or consumer reporting agency or through a personal telephone interview to release to Combined Insurance Company of America any information regarding the insured, or past or present health of the insured for the purpose of evaluating this application for insurance. I also authorize Combined Insurance Company of America or its reinsurers to disclose all such information to any doctor, the Medical Information Bureau, Inc. or any other insurance company in order to evaluate a claim or an application for insurance.

This authorization shall remain valid for a period of two years from the date of application. A photocopy of this authorization will be as valid as the original. A copy of the authorization is available to you or your representative upon request to the Company.

You may revoke this authorization anytime by writing Combined; however, such revocation may affect coverage.

I authorize Combined to show my name as a policyholder to prospective insureds.

Failure to sign this authorization may impair the ability of Combined to evaluate or process this application and may be a basis for denying this application.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

YES

NO

X	Date of Application:	
Signature of Insured		
City (where signed):	State:	
I, the authorized agent/producer, have on the Date of Application recorded the in Practices, and where applicable, the Outline of Coverage. I have no knowledge I certify that I have inspected this application for completeness and according to Office for further underwriting review.	of any unfavorable medical history	not recorded on this Application.
Agent's /Dredu	oor'o	

office for fartifer affaorwriting review.		
icensed gent/Producer	Agent's/Producer's Signature Code #	
(print)	·	
ales Nanager	Manager's Signature Code #	
(print)	Home Office use only	
	Complete this area when splitting commissions	

Date William DD 1111111	Primary	Secondary
Primary Agent/Producer contact information	Agent/Producer Name	Agent/Producer Name
Agent's/Producer's phone	Code #	Code #
Agent's/Producer's e-mail address	Percentage	Percentage
Agent's/Producer's cell phone	Agent's/Producer's Signature	Agent's/Producer's Signature

Date MM DD YYYY

Agent/Producer Code Number



5005164016

Name of Financial Institution:  BANK ACCOUNT NUMBER  AUTHORIZATION FOR ELECTRONIC DEBIT  hereby authorize Combined Insurance Company (Combined?), to initiate electronic debit entries or effect a change by any other commerciacocepted method, to my checking or savings account indicated above in the financial institution named above, hereinather called Depository, to de he same to such account. This authority is to remain in full force and effect until Combined and Depository have each received written notification of its termination in such time and in such manner as to afford Combined and Depository have each received written notification of its termination in such time and in such manner as to afford Combined and Depository have each received written notification of its termination in such time and in such manner as to afford Combined and Depository have each received written notification of its termination in such time and in such manner as to afford Combined and Depository have each received written notification of its termination in such time and in such manner as to afford Combined and Depository have each received written notification of its termination in such time and in such manner as to afford Combined and Depository have each received written notification of its termination in such time and in such manner as to afford Combined and Depository have each received written notification and learner and the such as a such as		(Automatic Premium for M	M COLLECTION  Monthly Mode ONLY)					
Complete if adding policies from another application =   Complete if adding policies in the policy in the policy in the financial institution named above, hereinafter called Depository, to de   the same to such account. This authority is to remain in full force and effect until Combined and Depository have each received written notification me of its termination in such time and in such manner as to afford Combined and Depository have each received written notification me of its termination in such time and in such manner as to afford Combined and Depository have each received written notification me of its termination in such time and in such manner as to afford Combined and Depository have each received written notification me of its termination in such time and in such manner and benefit increase provision, future premiums will increase as indicated in the policy five intermination in the policy intermination in the policy intermination in the policy intermination in the policy five intermination in the policy intermination in	Name of Financial Institution:		City:				State	
Charge my Checking Savings Initial Premium Collected \$ Policy Type The Health)  Preferred Billing Date   AUTHORIZATION FOR ELECTRONIC DEBIT    Inereby authorize Combined Insurance Company ("Combined"), to initiate electronic debit entries or effect a change by any other commercia coperted method, to my checking or savings account indicated above in the financial institution named above, hereinafter called Depository, to de he same to such account. This authority is to remain in full force and effect until Combined and Depository have each received written notification me of its termination in such time and in such manner as to afford Combined and Depository have each received written notificated that if any listed policy contains a premium and benefit scheedule, agree that if premiums are not paid within the grace period under the subject policy(ies), as in the event withdrawals are dishonored, the policy(iii) in understand that if any listed policy contains a premium and benefit scheedule.  **Signature of Payer**  **Date:** MIM** DID** YYYY  **Amount of Insurance**  **COMBINED INSURANCE COMPANY OF AMERICA * 5.050 N. Broadway * Chicago, Illinois 60640 CONDITIONAL RECEIPT IMPORTANT READ CAREFULLY  Payment of Premium Does Not Provide Insurance Coverage Until All Conditions Specified Below Are Satisfied. Also Note Limitation On Coverage Specified Below.  **CONDITIONAL RECEIPT IMPORTANT READ CAREFULLY  Payment of Premium Does Not Provide Insurance Coverage Is Effective:  If both of the following conditions for any person proposed to be insured in the application are satisfied:  1. The first premium has been paid with the application; and  2. The Company, upon investigation, is satisfied than the date of this receipt shown below, such person was an acceptable risk according to the Company's rules and regulations for the plan and amount of insurance applied for;  Effective Date of Coverage:  **Effective Date of Coverage:**  **In the proposed of the proposed Insured prior to issuance of the policy(ies) such insurance		DUNT NUMBER	Oily.				Olato	•
Charge my Checking Savings Initial Premium Collected \$ Policy Type The Health)  Preferred Billing Date   AUTHORIZATION FOR ELECTRONIC DEBIT    Inereby authorize Combined Insurance Company ("Combined"), to initiate electronic debit entries or effect a change by any other commercia coperted method, to my checking or savings account indicated above in the financial institution named above, hereinafter called Depository, to de he same to such account. This authority is to remain in full force and effect until Combined and Depository have each received written notification me of its termination in such time and in such manner as to afford Combined and Depository have each received written notificated that if any listed policy contains a premium and benefit scheedule, agree that if premiums are not paid within the grace period under the subject policy(ies), as in the event withdrawals are dishonored, the policy(iii) in understand that if any listed policy contains a premium and benefit scheedule.  **Signature of Payer**  **Date:** MIM** DID** YYYY  **Amount of Insurance**  **COMBINED INSURANCE COMPANY OF AMERICA * 5.050 N. Broadway * Chicago, Illinois 60640 CONDITIONAL RECEIPT IMPORTANT READ CAREFULLY  Payment of Premium Does Not Provide Insurance Coverage Until All Conditions Specified Below Are Satisfied. Also Note Limitation On Coverage Specified Below.  **CONDITIONAL RECEIPT IMPORTANT READ CAREFULLY  Payment of Premium Does Not Provide Insurance Coverage Is Effective:  If both of the following conditions for any person proposed to be insured in the application are satisfied:  1. The first premium has been paid with the application; and  2. The Company, upon investigation, is satisfied than the date of this receipt shown below, such person was an acceptable risk according to the Company's rules and regulations for the plan and amount of insurance applied for;  Effective Date of Coverage:  **Effective Date of Coverage:**  **In the proposed of the proposed Insured prior to issuance of the policy(ies) such insurance								
Charge my Checking Savings Initial Premium Collected \$ PolicyType (L = Ute, H = Health)  Preferred Billing Date AUTHORIZATION FOR ELECTRONIC DEBIT  hereby authorize Combined Insurance Company (Combined'), to initiate electronic debit entries or effect a change by any other commercial cocepted method, to my checking or savings account indicated above in the financial institution named above, hereinather called Depository, to de he same to such account. This authority is to remain in full force and effect until Combined and Depository have each recovered written notification me of its termination in such time and in such manner as to afford Combined and Depository a reasonable opportunity to act on it. understand that if any listed policy contains a premium and benefit increase provision, future premiums will increase as indicated in the pol Premium and Benefit schedule.  agree that if premiums are not paid writhin the grace period under the subject policy(ies), as in the event withdrawals are dishonored, the policy(iii) iterminate. Life policies may have non-forfeiture benefits.  Date: MIM DID WIVWW  Amount of Insurance  COMBINED INSURANCE COMPANY OF AMERICA • 5050 N. Broadway • Chicago, Illinois 60640  CONDITIONAL RECEIPT IMPORTANT READ CAREFULLY  Payment of Premium Does Not Provide Insurance Coverage Until All Conditions Specified Below Are Satisfied. Also Note Limitation On Coverage Specified Below.  Conditions Which Must Be Satisfied Before Coverage Is Effective:  If both of the following conditions for any person proposed to be insured in the application are satisfied:  1. The first premium has been paid with the application; and  2. The Company, upon investigation, is satisfied that on the date of this receipt shown below, such person was an acceptable risk according to the Company's rules and regulations for the plan and amount of insurance applied for;  Effective Date of Coverage:  The first premium has been paid with the application; and an authority income policy, monthly payments may not exceed a tota								
Preferred Billing Date  AUTHORIZATION FOR ELECTRONIC DEBIT  hereby authorize Combined Insurance Company ("Combined"), to initiate electronic debit entries or effect a change by any other commercia accepted method, to my checking or savings account indicated above in the financial institution named above, hereinafter called Depository, to de the same to such account. This authority is to remain in full force and effect until Combined and Depository have each received written notification me of its termination in such time and in such manner as to afford Combined and Depository a reasonable opportunity to act on it. understand that if any listed policy contains a premium and benefit increase provision, future premiums will increase as indicated in the policy fixed premium and benefit schedule.  agree that if premiums are not paid within the grace period under the subject policy(ies), as in the event withdrawals are dishonored, the policy(ie) will terminate. Life policies may have non-forfeiture benefits.  **COMBINED INSURANCE COMPANY OF AMERICA** 5050 N. Broadway** Chicago, Illinois 60640 CONDITIONAL RECEIPT IMPORTANT READ CAREFULLY  Payment of Premium Does Not Provide Insurance Coverage Until All Conditions Specified Below Are Satisfied. Also Note Limitation On Coverage Specified Below.  Conditions Which Must Be Satisfied Before Coverage Is Effective: If both of the following conditions for any person proposed to be insured in the application are satisfied:  1. The first premium has been paid with the application; and  2. The Company, upon investigation, is satisfied that on the date of this receipt shown below, such person was an acceptable risk according to the Company's rules and regulations for the plan and amount of insurance applied for; Effective Date of Coverage:  Then, if both of the above conditions are satisfied, the insurance applied for on such person shall take effect on the date of application.  Limitation of Certain Coverage:  If may of the above conditions are not met, the policy(ies) applied fo	NAME OF PAYOR APPEARING ON BANK/FINANCIAL INSTITUT	ION			110111 8	mother a	opiicatioi	
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Date

Authorized Agent/Producer



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	(Automatic Premium for Mo	onthly Mode ONLY)	
Name of Financial Institution:		City:	State:
BANK ROUTING NUMBER	BANK ACCOUNT NUMBER		
NAME OF PAYOR APPEARING ON BANK/FINA	ANCIAL INSTITUTION		Complete if adding policies from another application –
		D.U. T	
Charge my Checking Savin	gs Initial Premium Collected \$	Policy Type (L = Life, H = Health)	
Preferred Billing Date			
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If any check, draft or money	order given in payment of the premiun	n is not honored, this receip	pt shall be void.
Proposed Insured			
1			
Date	Authorized Agent/Producer	<del></del>	/Producer Code Number

 ${\it Company Tracking Number:} \qquad 164016\hbox{-}AR\hbox{--}APPLICATION FOR ACCIDENT AND HEALTH INSURANCE}$ 

TOI: H021 Individual Health - Accident Only Sub-TOI: H021.000 Health - Accident Only

Product Name: 164016-AR - Application for Accident and Health Insurance

Project Name/Number: 164016-AR - Application for Accident and Health Insurance/164016-AR - Application for Accident and Health Insurance

## **Rate Information**

Rate data does NOT apply to filing.

Company Tracking Number: 164016-AR - APPLICATION FOR ACCIDENT AND HEALTH INSURANCE

TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only

Product Name: 164016-AR - Application for Accident and Health Insurance

Project Name/Number: 164016-AR - Application for Accident and Health Insurance/164016-AR - Application for Accident and Health Insurance

## **Supporting Document Schedules**

**Review Status:** 

Satisfied -Name: Certification/Notice Approved-Closed 05/07/2008

Comments: Attachment:

Certification of Compliance.pdf

Review Status:

05/07/2008

Bypassed -Name: Application Approved-Closed 05/07/2008

Bypass Reason: Not applicable, filing an application for approval

**Comments:** 

Review Status:

Bypassed -Name: Health - Actuarial Justification Approved-Closed

Bypass Reason: Not Applicable, filing an application.

Comments:

Review Status:

Bypassed -Name: Outline of Coverage Approved-Closed 05/07/2008

Bypass Reason: Not Applicable, filing an application.

Comments:

Review Status:

Satisfied -Name: Readability Certification Approved-Closed 05/07/2008

Comments: Attachment:

164016 flesch score.pdf

Review Status:

Satisfied -Name: Cover Letter Approved-Closed 05/07/2008

Comments: Attachment:

164016 Cover Letter.pdf

Company Tracking Number: 164016-AR - APPLICATION FOR ACCIDENT AND HEALTH INSURANCE

TOI: H021 Individual Health - Accident Only Sub-TOI: H021.000 Health - Accident Only

Product Name: 164016-AR - Application for Accident and Health Insurance

Project Name/Number: 164016-AR - Application for Accident and Health Insurance/164016-AR - Application for Accident and Health Insurance

**Review Status:** 

Satisfied -Name: Variable Memorandum Approved-Closed 05/07/2008

Comments: Attachment:

Variable Memorandum.pdf

**Review Status:** 

Satisfied -Name: 6-04-08 Filing Letter Approved-Closed 06/04/2008

Comments: Attachment:

6-04-08 - Filing Letter 164016-AR.pdf

# **Certificate of Compliance with Arkansas Rule and Regulation 19**

Insurer: Combined Insurance Company of America
Form Number(s): 164016-AR - Application for Accident and Health Insurance
I hereby certify that the filing above meets all applicable Arkansas requirements including the
requirements of Rule and Regulation 19.
Signature of Company Officer
Michael J. Hollar Name
Assistant Secretary
Title
May 6, 2008
Date



## READABILITY CERTIFICATION

RE: Form No. 164016-AR - Application for Accident & Health Insurance Coverage

We hereby certify that the above captioned form has a Flesch Index Score of <u>50</u> and meets the reading ease requirements.

Michael J. Hollar Michael J. Hollar Assistant Secretary



### 1000 Milwaukee Avenue, Glenview, Illinois 60025

## **VIA SERFF**

May 6, 2008

Mr. Dan Honey Arkansas Insurance Department 1200 West 3<sup>rd</sup> Street Little Rock, Arkansas 72201

RE: SERFF Tracking Number: CMBD-125630654

**Combined Insurance Company of America** 

FEIN Number 36-2136262 NAIC Number 317-62146

Form No. 164016-AR - Application for Accident & Health Insurance Coverage

164016-1H - Conditional Receipt

**Individual Accident and Health** 

Dear Mr. Honey:

This is a new filing. Application 164016-AR is a new form which will not replace any existing applications. Application 164016-AR will be used with our previously approved accident and health forms (listed below) and is being filed as variable to allow it to be used with any future form filings. These forms are solicited on a face-to-face basis by our Insurance Producers or by direct market for telephone and mail solicitation.

Form No.	Description	<b>Approval Date</b>
14028-AR	Accident Only Policy	August 25, 2005
12400-AR	Sickness Only Rider	April 13, 2006
16075-AR	Cancer Only Policy	December 31, 1987
16521-AR	Specified Critical Condition Policy	February 27, 2002
16402	20 Year Paid Up Rider	February 27, 2002
19819-AR	Disability Income Policy	May 13, 1996
19423	Extended Benefits for Total Disability Rider	May 13, 1996

Please consider the arrangement of the information on the application as variable. The information may be rearranged to accommodate data processing or marketing needs but the information will remain the same. The variable bracketed areas are all inclusive; however, we may delete boxes, if necessary, based on our marketing decisions for the policy plans. A variable memorandum is attached.

**TO: Arkansas Insurance Department** 

RE: Form No. 164016-AR

May 6, 2008 Page 2

Also, enclosed are the following:

- 1. A \$50 retaliatory filing fee has been submitted by EFT
- 2. Readability Certification
- 3. Certificate of Compliance

We appreciate your time in reviewing this filing. Please call me at our toll free number or email me if you have further questions or need additional information.

COMBINED INSURANCE COMPANY

Sincerely, Lleborah Shortridge

Deborah Shortridge, HIA, DHP, DIA Senior Policy Analyst



## Combined Insurance Company of America

1000 Milwaukee Avenue • Glenview, Illinois 60025

#### Variable List for form 164016

<u>Variable</u> **Options** Page 1 All-inclusive. 1. [Language Preference area] May be deleted if only offered in English or English/Spanish, or English/French. [Social Security Number] May be deleted if we decide not to use. Page3 Bracketed to allow for a future change in the [Form Number] policy form number. All-inclusive. [Plan Code: ASP/CAP/CCP/DI1] May be deleted if we stop selling a policy. Bracketed to allow for us to remove or add to Coverage and Plan Options options without having to refile this application. Amount of Insurance Benefit/Elimination Periods Income Protection Benefit Will be Limited to the rating information approved in connection with the policies. Yes and No box and modal premium amount **6.** [Return of Premium/Paid Up Rider] to be deleted if we decide to market the CAP and CCS without the Riders. Bracketed to allow for removal of a particular 7. Renewal Modes mode option. All-inclusive. 8. Premium & Billing Information When system allows, applicant can choose date of billing and whether it is charged to the Saving or Checking account monthly. May be deleted. May be deleted if we stop selling the Page 4 indicated policy. Please read carefully items 3,4, & 5.

3. If applying for an Accident Only Policy..."4. If applying for a Critical Condition Protector..."

5. If applying for Cancer Protector..."

#### Variable List for form 164016

All-inclusive. **10.** [Home Office use only] May be deleted if we do not offer split

commission.

May be deleted if it is decided to have 11. [Automatic Premium Collection] Automatic Premium Collection a separate

document.

Bracketed to allow for removal of this deduction 12. [Savings]

location option.

Bracketed to allow for removal of this deduction **13.** [Preferred Billing Date]

location option.



#### **VIA SERFF**

June 4, 2008

Ms. Rosalind Minor Arkansas Insurance Department 1200 West 3<sup>rd</sup> Street Little Rock, Arkansas 72201

RE: Combined Insurance Company of America

FEIN Number 36-2136262 NAIC Number 317-62146

Form No. 164016-AR - Application for Accident & Health Insurance Coverage

164016-1H - Conditional Receipt

**Individual Accident and Health** 

Dear Ms. Minor:

Attached is a substitute filing for the above captioned previously approval by your Department on May 7, 2008 under SERFF Tracking Number CMBD-125630654.

The form is identical to the form previously approved except for the following changes:

- 1. Changed Insured's Mailing address to Billing address;
- 2. Added call type address for home or business with check boxes;
- 3. Section 6 Dependent Information added check boxes of Male or Female for Spouse.

No other changes, except as stated above, have been made. This form has not yet been made available for use or issued.

We appreciate your extending your approval to the enclosed forms. Please call me at our toll free number or email me if you have further questions or need additional information.

COMBINED INSURANCE COMPANY

Reborah Shortridge

Sincerely,

Deborah Shortridge, HIA, DHP, DIA

Senior Policy Analyst

Company Tracking Number: 164016-AR - APPLICATION FOR ACCIDENT AND HEALTH INSURANCE

TOI: H021 Individual Health - Accident Only Sub-TOI: H021.000 Health - Accident Only

Product Name: 164016-AR - Application for Accident and Health Insurance

Project Name/Number: 164016-AR - Application for Accident and Health Insurance/164016-AR - Application for Accident and Health Insurance

# **Superseded Attachments**

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date: Schedule Document Name Replaced Date Attach

**Document** 

No original date Form Application for Accident and Health 05/06/2008 164016-AR.pdf

Insurance

5 0 0 1

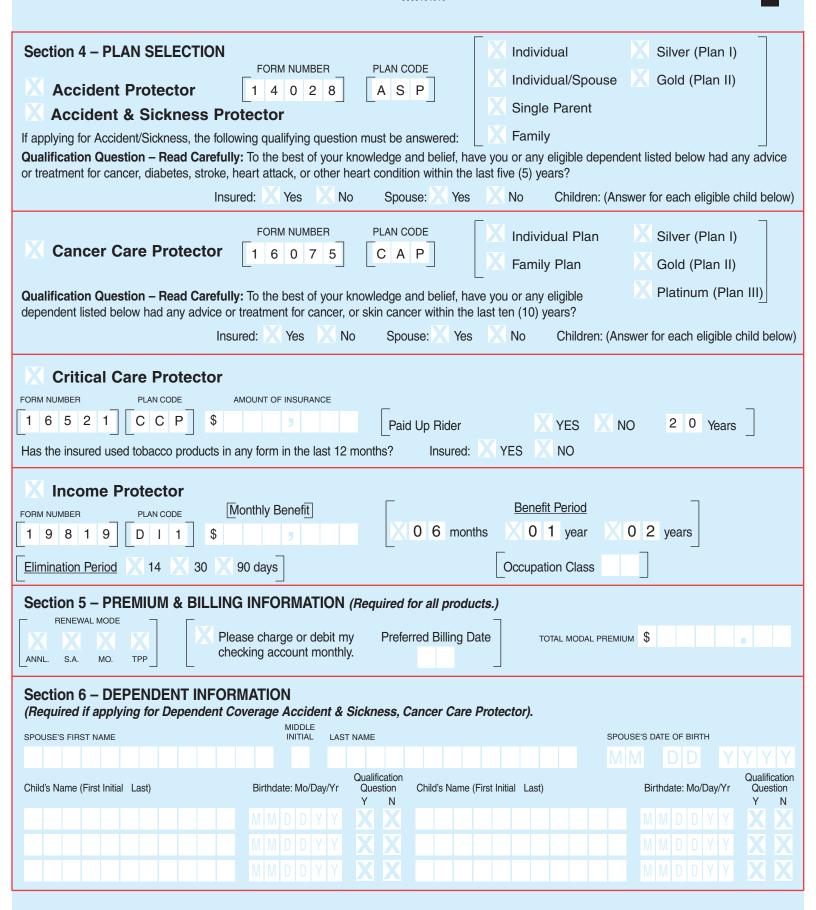
Section 1 – BASIC INFORMATION (Required for all produc	, LANGOAGE I HEI EHENOE
M F INSURED'S FIRST NAME	MIDDLE INITIAL LAST NAME
INSURED'S RESIDENCE ADDRESS	RESIDENCE PHONE NUMBER
CITY	STATE ZIP
INSURED'S DATE OF BIRTH INSURED'S AGE	REF/LINK
INSURED'S MAILING ADDRESS IF DIFFERENT FROM RESIDENCE	POLICY NUMBER SOCIAL SECURITY NUMBER
INCOMED O MALENCE ADDITION IN ELICITIFICATION INCOMEDICATION	GOOIAL SECURITI NOMBER
CITY	STATE ZIP
Is any person applying for coverage on Medicaid? XYES XNO Wi	II this policy replace any existing policies? YES NO
An Authorized Interviewer may call to obtain additional information required to co	mplete this application. Check most convenient place and time to call:
Home Business ( ) Additional	al No. (Cell) ( )
6:30 am - 8:00 am 8:00 am - 12:00 pm 12:00 pm - 3:00 pm	3:00 pm - 6:00 pm After 6:00 pm
(Required for Income Protector and optional for other coverages.)	
INSURED'S BUSINESS NAME	BUSINESS PHONE NUMBER
INSURED'S BUSINESS ADDRESS	
CITY	STATE ZIP
(Required if Payor different from Insured.)	
PAYOR'S FIRST NAME (IF OTHER THAN INSURED) INITIAL LAST NAME	
PAYOR'S RESIDENCE ADDRESS (IF OTHER THAN INSURED)	
	OTATE TIP
CITY	STATE ZIP
(Required for Critical Care Protector.)  BENEFICIARY'S FULL NAME (IF REQUIRED)	RELATIONSHIP TO INSURED
DENEFICIARY S FULL NAME (IF REQUIRED)	RELATIONSHIP TO INSURED
Ocalica O FMDI OVMENT O INCOME INFORMATION (5. 1.1.1	
Section 2 – EMPLOYMENT & INCOME INFORMATION (Required	if applying for Income Protector only.)
1. Insured's Occupation	
Please describe all employment duties performed in detail:	
3. I certify that my gross annual earnings, or net earnings if self-employed, at ti	imo of application (without overtime upless
overtime is contractual, and without other bonuses or incentives) is:	The or application (without overtime, unless
4. Are you self employed or have you been working for the same employer for	less than 6 months? (A telephone interview
may be required.)	
5. Do you currently work in your primary occupation, performing all primary du	
o. Do you ourronly work in your primary occupation, performing all primary du	also, and work at load to flour of flore per work:
6. Do you currently have any other in force disability coverage with another car	wie vO



## Section 3 – UNDERWRITING INFORMATION (Required for Income Protector and Critical Care Protector only.)

INSUR	ED'S HEIGHT INSU	JRED'S WEIGH	IT INSU	JRED'S DRIVERS	LICENSE		STATE			
F	T. IN.		LBS.						Insu	red
1.			d any medical ADVI n MEDICINE within			m a member	of the medical profe	ssion,	<u>Yes</u>	<u>No</u>
		·				9		.10	X	Y
	Ū			_			art valve replacemer	1Γ <i>?</i>		
		·	ler, cirrhosis of the I	_	·					
			orain tumor, Hodgkir							
			dementia, Parkinso		·					
	e. Chronic Ob	structive I	_ung/Pulmonary dis	ease, Emph	nysema or o	ther lung dise	ase requiring oxyge	n?		
	f. Manic depre	ession, so	chizophrenia, alcoho	olism or drug	g addiction?					
2.	Is the insured	listed on t	his application for ir	surance an	insulin dep	endent diabet	ic?			
3.			•				naving AIDS (Acquir / (Human Immunode			
4.	Has the insure	d been co	onvicted of reckless	driving or d	riving under	the influence	of alcohol within the	e past 5 years?		
5.	Is the insured	currently (	on Disability? (exclu	ding Military	/ Disability)					
	If any of the a	bove que	estions are answer	ed "Yes", t	he insured	is not eligibl	e for coverage.			
6.			for or received Disa nin the last 12 mont	•	its (includinç	g that from Wo	orker's Compensatio	n, Social Security		
7.			he application for in " answer when ap			•	petic taking oral med lifies applicant.)	dication and/or		
8.	•		nas a member of the ne back, neck, spine	•	ofession dia	gnosed you v	vith or treated you fo	r an injury,		
9.			nsured's parents, bro they were under th			iagnosed with	heart disease, cand	cer, or any		
10.	Within the past	t 5 years h	nave you had any m	edical advid	ce, diagnost	ic tests or trea	atment from a memb	er of the		
	flu, colds and r	outine phy		answered	•		ondition(s) not listed  10 explain below.)	•		
Bas					nd/or evalu	ation of you	application an exc	clusionary rider for	specif	ic
			ocational activities					,		
	Health Condition	on	Medication/Dosage	Treatment?	Surgery?	Dates	Physician(s) Name: Ac	ldress (Street, City, Stat	e, Zip) &	Phone
				Voc. No.	Voc. No.					
				Yes No	Yes No					
				Yes No	Yes No					
				Yes No	Yes No					







## Section 7 – DECLARATIONS – This section must be read, signed, and dated by Insured.

#### PLEASE READ CAREFULLY

It is very important that you review the application carefully. Misstatements or omissions whether made in writing or orally for any portion(s) of the application that are completed through use of telephone or other electronic means, could cause an otherwise valid claim to be denied. Please check the application carefully and advise your agent/producer if any information is not correct or not complete or if any medical history has not been included. I understand that any insurance applied for will not take effect unless and until Combined Insurance Company of America approves my application, the contract is issued, and the required premium is received by Combined Insurance Company of America.

In applying for this coverage, I represent and affirm the following:

- The information which I have given as recorded on this Application including income verification is true and complete to the best of my knowledge and belief.
- 2. I have received the Medical Information Bureau (MIB) Disclosure Statement, the notice under the Fair Credit Reporting Act, Notice of Information \_\_ Practices, and (if applicable) Outline of Coverage.
- 3. If applying for an Accident Only policy, I understand that the policy does not provide benefits for loss from sickness.
- 4. If applying for Critical Care Protector, I understand that the policy: 1) is NOT major medical and NOT meant to replace medical expense insurance; and 2) is NOT life insurance; and I am not covered by any Title XIX program (Medicaid or any similar name).
- 5. If applying for the Cancer Care Protector Policy, I understand that the policy is cancer only and does not pay benefits for loss from any other sickness or from accidents. FOR PERSONS ELIGIBLE FOR MEDICARE: I acknowledge receipt of the "Guide to Health Insurance" and duplication notice.

#### **AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

I authorize Combined Insurance Company of America or its reinsurers to acquire from and authorize any hospital, physician, medical practitioner, clinic, medically related facility, insurance company, the Medical Information Bureau, Inc. (MIB) or consumer reporting agency or through a personal telephone interview to release to Combined Insurance Company of America any information regarding the insured, or past or present health of the insured for the purpose of evaluating this application for insurance. I also authorize Combined Insurance Company of America or its reinsurers to disclose all such information to any doctor, the Medical Information Bureau, Inc. or any other insurance company in order to evaluate a claim or an application for insurance.

This authorization shall remain valid for a period of two years from the date of application. A photocopy of this authorization will be as valid as the original. A copy of the authorization is available to you or your representative upon request to the Company.

You may revoke this authorization anytime by writing Combined; however, such revocation may affect coverage.

I authorize Combined to show my name as a policyholder to prospective insureds.

Failure to sign this authorization may impair the ability of Combined to evaluate or process this application and may be a basis for denying this application.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

YES

NO

X	Date of Application:	
Signature of Insured		
City (where signed):	State:	
I, the authorized agent/producer, have on the Date of Application recorded the in Practices, and where applicable, the Outline of Coverage. I have no knowledge I certify that I have inspected this application for completeness and according to Office for further underwriting review.	of any unfavorable medical history	not recorded on this Application.
Agant's /Dradu	oor'o	

office for fartifer affaorwriting review.		
icensed gent/Producer	Agent's/Producer's Signature Code #	
(print)	·	
ales Nanager	Manager's Signature Code #	
(print)	Home Office use only	
	Complete this area when splitting commissions	

Date William DD 1111111	Primary	Secondary
Primary Agent/Producer contact information	Agent/Producer Name	Agent/Producer Name
Agent's/Producer's phone	Code #	Code #
Agent's/Producer's e-mail address	Percentage	Percentage
Agent's/Producer's cell phone	Agent's/Producer's Signature	Agent's/Producer's Signature

Date MM DD YYYY

Agent/Producer Code Number



5005164016

(Automatic Premium for Monthly Mode ONLY)  Name of Financial Institution:  BANK ACCOUNT NUMBER  Complete it adding poticies from another application		AUTOMATIC P	REMIUM C	OLLECTION	VI.							
Charge my Checking Savings Initial Premium Collected SAUTHORIZATION FOR ELECTRONIC DEBIT  Charge my Checking Savings Initial Premium Collected SAUTHORIZATION FOR ELECTRONIC DEBIT  Hereby authorize Combined Insurance Company ('Combined'), to initiate electronic debit entries or effect a change by any other commercia accepted method, to my checking or savings account indicated above in the firanacial institution named above, hereinafter called Depository, to del the same to such account. This authority is to remain in full force and effect until Combined and Depository have each received written notification me of its termination in such time and in such manner as to afford Combined and Depository have each received written notification me of its termination in such time and in such manner as to afford Combined and Depository have each received written motification me of its termination in such time and in such manner as to afford Combined and Depository have each received written motification me of its termination in such time and in such manner as to afford Combined and Depository have each received written motification me of its termination in such intermediation and Depository have each received written motification me of its termination in such as a sufficient in the policy flew in the mention of the policy flew in terminate. Life policies may have non-forfeture benefits.  X Date: MIM DD YYYYYY  Payment of Premium Does Not Provide Insurance Coverage Until All Conditions Specified Below Are Satisfied. Also Note Limitation On Coverage Specified Below.  Conditions Which Must Be Satisfied Before Coverage Is Effective.  1 The first premium has been paid with the application; and  2. The Company, upon investigation, is satisfied that on the date of this receipt shown below, such person was an acceptable risk according to the Company's rules and regulations for the plan and amount of insurance applied for; Effective Date of Coverage:  Effective Date of Coverage:  How Company is proposed Insurance prior to issuance												
Charge my Checking Savings Initial Premium Collected Sauthorized Billing Date AUTHORIZATION FOR ELECTRONIC DEBIT  I hereby authorize Combined Insurance Company (*Combined*), to initiate electronic debit entries or effect a change by any other commercia accepted method, to ny checking or savings account indicated above in the financial institution named above, hereinafter called Depository, to we design or savings account indicated above in the financial institution named above, hereinafter called Depository, to expend the same to such account. This authority is to remain in full force and effect until Combined and Depository have each received written notification on the same to such account. This authority is to remain in full force and effect until Combined and Depository have each received written notification on the same to such account. This authority is to remain in full force and effect until Combined and Depository have each received written notification on the same to such account. This authority is to remain in full force and effect until Combined and Depository have each received written notification from more of its terminate and policy operations. The programment of the policy operation and premiums and Benefit schedule.  I larger that if premiums are not paid within the grace period under the subject policy(ies), as in the event withdrawals are dishonored, the policy(iew) in terminate. Life policies may have non-forfeiture benefits.  X Date: MIM DID YYY YY  Payment of Premium Does Not Provide Insurance Coverage Until All Conditions Specified Below Are Satisfied. Also Note Limitation On Coverage Specified Below.  CONDITIONAL RECEIPT IMPORTANT READ CAREFULLY  Payment of Premium Does Not Provide Insurance Coverage Until All Conditions Specified Below Are Satisfied. Also Note Limitation On Coverage Specified Below.  Conditions Which Must Be Satisfied Before Coverage Is Effective.  If both of the following conditions for any person proposed to be insured in the application are satisfied:  1. The first	Name of Financial Institution:			City:							State	):
Charge my Checking Savings Initial Premium Collected \$ Policy Type The Health)  Preferred Billing Date AUTHORIZATION FOR ELECTRONIC DEBIT  I hereby authorize Combined Insurance Company ("Combined"), to initiate electronic debit entries or effect a change by any other commercial accepted method, to my checking or savings account indicated above in the financial institution named above, hereinafter called Depository, to de the same to such account. This authority is to remain in full force and effect until Combined and Depository have each received written notificating rom me of its termination in such time and in such manner as to afford Combined and Depository are easonable opportunity to act on it.  Lunderstand that if any listed policy contains a premium and benefit increase provision, future premiums will increase as indicated in the policy few will terminate. Life policies may have non-forfeiture benefits.  X	BANK ROUTING NUMBER BANK	ACCOUNT NUMBER										
Charge my Checking Savings Initial Premium Collected \$ PolicyType (L Use, H - Healm)  Preferred Billing Date  AUTHORIZATION FOR ELECTRONIC DEBIT  Hereby authorize Combined Insurance Company ("Combined"), to initiate electronic debit entries or effect a change by any other commercia accepted method, to my checking or savings account indicated above in the financial institution named above, hereinafter called Depository, to del the same to such account. This authority is to remain in full force and effect until Combined and Depository have each received written notification me of its termination in such time and in such manner as to a direct Combined and Depository are assonable opportunity to act on it. I understand that if any listed policy contains a premium and benefit increase provision, future premiums will increase as indicated in the policy flew will terminate. Life policies may have non-forfeiture benefits.  **Date:** MIM** DID** YIV** YIV**  **Signature of Payor**  **COMBINED INSURANCE COMPANY OF AMERICA * 5050 N. Broadway * Chicago, Illinois 60640 CONDITIONAL RECEIPT Important READ CAREFULLY  Payment of Premium Does Not Provide Insurance Coverage Until All Conditions Specified Below Are Satisfied. Also Note Limitation On Coverage Specified Below.  **CONDITIONAL RECEIPT Important READ CAREFULLY**  Payment of Premium Does Not Provide Insurance Coverage Is Effective:  If both of the following conditions for any person proposed to be insured in the application are satisfied:  1. The first premium has been paid with the application; and  2. The Company, upon investigation, is satisfied that on the date of this receipt shown below, such person was an acceptable risk according to the Company's rules and regulations for the plan and amount of insurance applied for;  Effective Date of Coverage:  Provided that in the event of death of the Proposed Insured prior to issuance of the policy(ies) such insurance applied for under the application.  Limitation of Certain Coverage:  Provided that in the event of death												
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Signature of Payor  Amount of Insurance \$  COMBINED INSURANCE COMPANY OF AMERICA • 5050 N. Broadway • Chicago, Illinois 60640 CONDITIONAL RECEIPT IMPORTANT READ CAREFULLY  Payment of Premium Does Not Provide Insurance Coverage Until All Conditions Specified Below Are Satisfied. Also Note Limitation On Coverage Specified Below.  Conditions Which Must Be Satisfied Before Coverage Is Effective:  If both of the following conditions for any person proposed to be insured in the application are satisfied:  1. The first premium has been paid with the application; and  2. The Company, upon investigation, is satisfied that on the date of this receipt shown below, such person was an acceptable risk according to the Company's rules and regulations for the plan and amount of insurance applied for;  Effective Date of Coverage:  then, if both of the above conditions are satisfied, the insurance applied for on such person shall take effect on the date of application.  Limitation of Certain Coverage:  Provided that in the event of death of the Proposed Insured prior to issuance of the policy(ies) such insurance applied for under the application is limited to \$50,000 as a lump sum under each policy, or if a monthly income policy, monthly payments may not exceed a total of \$50,000 under each policy.  If any of the above conditions are not met, the policy(ies) applied for will not take effect unless and until the first premium is paid and the policy is sued during such person's lifetime. In the event the application is declined, the payment shown on this receipt will be returned to the applicant. The application shall be deemed declined if the policy(ies) is (are) not issued within 60 days after the date of application.  Received from as First Full Premium Annual as First Full Premium Annual as First Full Premium Annual Annual as First Full Premium Annual Annual as First Full Premium Annual Annual	accepted method, to my checking or savin the same to such account. This authority if from me of its termination in such time an I understand that if any listed policy cont. Premium and Benefit schedule. I agree that if premiums are not paid within	Company ("Combined"), to igs account indicated above is to remain in full force an id in such manner as to aff ains a premium and benefin the grace period under th	initiate elect e in the finar d effect until ord Combin fit increase	etronic debit ncial institutio Combined a ed and Depo provision, fut	entries on name and De ository a ture pre	ed abov pository a reaso emiums	re, here r have nable will in	einafte each i opport icrease	r called receive unity to as in	d Dep ed wri o act dicate	ository tten no on it. ed in th	to del tification ne polic
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Date

Authorized Agent/Producer

Agent/Producer Code Number

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Charge my Checking Savin	gs 🔲 In	itial Premiur	m Collected	\$		Policy (L = Lit	<b>Type</b> fe, H =	Health)						
Preferred Billing Date hereby authorize Combined Instacepted method, to my checking the same to such account. This are me of its termination in such understand that if any listed polyremium and Benefit schedule.  agree that if premiums are not page	or savings a uthority is to time and in licy contains aid within the	npany ("Cor account indi o remain in to such manr s a premiun e grace peri	icated about full force ar ner as to af ner and beneated and under the code and and series are the code and and series are are as a code and and are the code and are	o initiate on the find effect up ford Come of the first come of the first come of the first contract c	electronic nancial ins Intil Comb bined and se provisio	debit entitution ined ar Deposon, futu	ntries name nd De sitory a re pre	ed abov positor a reaso emiums	ve, her y have nable s will i	reinaft e each oppo ncrea	er call receir rtunity se as	ed Dep ved wr to act indicat	oository itten no on it. ed in th	, to de tificat ne po
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Signature of Payor  COMBINED INSUE  COMBINED INSUE	ONDI	OMPAN	L REC	MERICA E <b>EIPT</b>	An Ir	mount nsurand N. Bi	of ce road	way •	FULL	Y.				On
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Date

Authorized Agent/Producer